SB 819 – WAIVER FOR OLDER ADULTS AND MEDICAID MANAGED CARE PILOT PROGRAM
Enrolled (Final) Version of Bill

Level-of-Care Expansion for Older Adults Waiver

- If permitted by CMS, expands definition of individuals determined to be medically-eligible for services under Medicaid Older Adults waiver if they require:
  - Skilled nursing facility care or other services
  - Rehabilitation services
  - Health-related services above the level of room & board that are available only through institutional facilities including individuals who because of severe cognitive impairments or other conditions:
    - Are currently unable to perform at least two activities of daily living without hands-on assistance or standby assistance from another individual, or have been or will be unable to perform at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity
    - Need substantial supervision for protection against threats to health and safety due to severe cognitive impairment

- If permitted by CMS, also expands eligibility criteria that includes medically-needy individuals whose countable income is above 300% of the applicable payment rate for SSI but is less than the average Medicaid reimbursement rate for long-term care after all deductions (including the protection from spousal impoverishment provisions of the federal Social Security Act)

- The Department's waiver amendment application is to include:
  - The opportunity to provide eligible individuals w/ waiver services as soon as they are available without waiting for placement slots to open in the next fiscal year
  - An increase in participant satisfaction
  - The forestalling of functional decline
  - A reduction in Medicaid expenditures by reducing utilization of services
  - The enhancement of compliance w/ Olmstead by operating cost-effective community-based services in the most appropriate setting

- The proportion of individuals who qualify for the expanded Older Adults waiver who are residents of the areas to be served by the managed care pilot program created under this bill <u>before</u> implementation of the pilot program must be the same <u>after</u> the implementation of the pilot program

- Waiver services are to be jointly administered by DHMH and the Department of Aging (DHR no longer part of waiver)

- DHMH to adopt regs to carry out provisions

Managed Care Pilot Program for Long-Term Care

- By November 1, 2004, DHMH to apply for a waiver to establish the Community Choice Program under which Medicaid program recipients are required to enroll in managed care entities known as 'community care organizations'

- Program to operate in two areas of the State

- Waiver application to include the following goals & objectives:
  - Increasing participant satisfaction
  - Allowing participants to age in place
  - Reducing Medicaid expenditures by encouraging the most appropriate utilization of high-quality services
  - Enhancing compliance w/ the Americans w/ Disabilities Act by offering the most cost-effective community-based services in the most appropriate high-quality and least-restrictive setting

- Benefits provided must include those services available under the Medicaid State Plan, as well as services covered under home- and community-based services waivers (except when services are limited or excluded by the Secretary); in addition:
  - All benefits under the pilot program are to be provided by community care organizations
  - Specific populations may be excluded from participating in the pilot program
  - DHMH must include a definition of "medical necessity" in its quality and access standards
  - Nursing homes are not precluded from utilizing an institutional pharmacy of its own choice for the provision of institutional pharmacy services and benefits for waiver enrollees in the nursing home

- Community Choice Program recipients must be allowed to choose among at least two community care organizations that have demonstrated a network capacity sufficient to meet the needs of the population

- On an annual basis or for cause, an enrollee may choose to disenroll from a community care organization and enroll in another one; in addition:
  - Enrollees receiving services in nursing homes, assisted living facilities, adult day care facilities, psychiatric rehabilitation programs or residential rehabilitation programs shall have the option of remaining in those facilities under the program
  - Enrollees who qualify for nursing home level-of-care may choose to receive services in a nursing home or in the community, if the community placement is cost-effective
  - The Community Choice Program must ensure that all enrollees maintain access to pharmacy benefits, including all classes of drugs, that are comparable to the benefits provided in the Medical Assistance program

- Each community care organization must provide for the benefits offered under the program, and they are not prevented from providing additional benefits that are not covered by a capitated rate; in addition:
  - The Department must make capitation payments set at a level that is actuarially adjusted for the benefits provided
  - The Department shall adjust the capitation payments to reflect the relative risk assumed by the community care organization

- The Department shall require community care organizations to be certified to accept capitated payments from the Medicare program for dual-eligibles

- The Community Choice Program shall include:
  - Adults who are dually-eligible
  - Adult Medicaid recipients who meet the nursing home level-of-care standard
  - Medicaid recipients over 65 years of age

- Individuals eligible for the Community Choice Program who require hospice care are required to receive hospice care from a licensed hospice program under a separate arrangement, and payment for this care shall be made directly to the hospice care program by the Department under the Medicaid-established rate for hospice care reimbursement

- Individuals eligible for the Community Choice Program who require specialty mental health services are required to receive specialty mental health services from an approved mental health provider under a separate arrangement, and payment for this care shall be made directly to the mental health provider by the Department under the Medicaid-established rate for specialty mental health services

- Each community care organization must meet all requirements for certification by the Department, and shall:
  - Have a quality assurance program (subject to approval by DHMH) that:
    - Provides for an enrollee grievance system, including an enrollee hotline
    - Provides for a provider grievance system, including a provider hotline
    - Provides for an enrollee satisfaction survey
    - Provides for a consumer advisory board to receive regular input from enrollees and submits an annual report to DHMH

- Submit service-specific data in a format specified by DHMH
- Include provisions for consumer direction of personal assistance services
- Ensure necessary provider capacity in all geographic regions where the community care organization is approved to operate
- Be accountable, and hold its subcontractors accountable, for meeting all requirements, standards, criteria or other directives of DHMH, and upon failure to meet those standards, be subject to one or more of the following penalties:
  - Fines
  - Suspension of further enrollment
  - Withholding of all or part of a capitation payment
  - Termination of a contract
  - Disqualification from future participation
  - Any other penalties that may be imposed by the Department
- Meet all the solvency and capital requirements for HealthChoice managed care organizations
- To the extent practicable, allow waiver enrollees who meet the nursing home level of care to select a nursing home, assisted living facility or adult day care facility provided that the facility is licensed by the Department and the provider meets the Department-approved credentialing requirements of the community care organization
- Submit to the Department utilization and outcome reports as directed by the Department
- Provide timely access to, and continuity of, health and long-term care services for enrollees
- Demonstrate organizational capacity to provide special population services, including outreach, case management and home-visiting, designed to meet the individual needs of all enrollees
- Provide assistance to enrollees in securing necessary health and long-term care services
- Comply with all relevant provisions of the federal Balanced Budget Act of 1997

- Community care organizations may not be have face-to-face or telephone contact or otherwise solicit an individual for the purpose of enrollment under the program

- In arranging for benefits under the program, community care organizations shall:
  - Reimburse nursing homes not less than the Medicaid-established rate based on the waiver recipient's medical condition plus allowable ancillary services, as established by the Department based on its nursing home Medicaid rate-setting methodology, except for waiver recipients who would have been paid for by Medicare for services provided, for whom they must reimburse nursing homes not less than the applicable reimbursement rate payable by Medicare for that waiver recipient
  - Reimburse nursing homes in accordance with the Department's policy on leave of absence as provided under §15-117
  - Reimburse adult day care facilities not less than the rate determined by the Department for Medical Assistance
  - Reimburse hospitals in accordance with rates established by HSCRC
  - Use a comprehensive care and support management team, including the primary care provider, nurse manager, case manager and other as appropriate for enrollees with complex long-term care needs
  - Reimburse a hospital emergency facility and provider for:
    - Health care services that meet the definition of emergency services under §19-701
    - Medical screening services rendered to meet the requirements of EMTALA
    - Medically-necessary services if the community care organization authorized, referred or otherwise allowed the enrollee to use the emergency facility and the medically-necessary services are related to the condition for which the enrollee was allowed to use the emergency facility
    - Medically-necessary services that relate to the condition presented and that are provided by the provider in the emergency facility to the enrollee if the community care organization fails to provide 24-hour access to a physician as required by the Department

- A provider may not be required to obtain prior authorization or approval for payment from a community care organization in order to obtain reimbursement under the program, and community care organizations are not prevented from providing a bonus or incentive for quality improvements

- Savings from the program shall be used to:
  - Assist medically and functionally impaired individuals in the community, or when discharged from a hospital, to receive home- and community-based waiver services
  - Increase reimbursement rates to community providers
  - Develop a single point-of-entry system consisting of a designated entity in each county and Baltimore City to:
    - Accept applications
    - Make all eligibility determinations
    - Enroll individuals in the program
    - Provide coordinated services, including level-of-care determinations, financial determinations, plan of care determinations, case management services and other services as needed

- In developing its waiver application, the Department shall solicit input from, and consult with, representatives of interested and affected parties, including legislators; affected state agencies; providers w/ expertise in dementia, geriatrics, end-of-life care and mental health; long-term care providers; managed care organizations; acute care providers; lay care givers; advocates for waiver-eligible candidates; and consumers

- In developing its waiver application, the Department shall:
  - Determine whether it is in the best interest of enrollees to provide for a standard prescription drug formulary and drug utilization review for medically-necessary drugs for waiver and non-waiver recipients in nursing homes
  - Consider maintaining the same nursing home prescription drug benefit and utilization review for all nursing home residents until implementation of the Medicare Prescription Drug , Improvement and Modernization Act of 2003

- DHMH must submit its proposed waiver application for the program to the Legislative Policy Committee for its review and comment before submitting it to CMS

Uncodified

- In developing its certification requirements for community care organizations, DHMH shall study ways to provide incentives for community care organizations that are locally owned, controlled and operated, and report to the Senate Finance Committee and the House Health & Government Operations Committee by September 30, 2004

- DHMH to annually report to the General Assembly on the status of the managed care pilot program beginning December 1, 2004

- DHMH shall initially submit emergency regulations to begin implementation of the managed care pilot program

- Unless further action is taken by the General Assembly, the managed care pilot program shall terminate at the end of May 31, 2008.

Effective Date

- Bill takes effect June 1, 2004